

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 08/28/2013 |
| NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00132541, IN00132978, and IN00134933.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to a Recertification and State Licensure Survey completed on 07/02/13. This visit included the PSR to the investigations of Complaints IN00128508, IN00128614, IN00128738, and IN00130059.</p> <p>Complaint IN00132541 substantiated, no deficiencies related to the allegation are cited.</p> <p>Complaint IN00132978 substantiated, no deficiencies related to the allegation are cited.</p> <p>Complaint IN00134933 substantiated, no deficiencies related to the allegation are cited.</p> <p>Survey dates: August 26, 27, and 28, 2013</p> <p>Facility number: 012766 Provider number: 155795 AIM number: 201051640</p> <p>Survey team: Regina Sanders, RN, TC Heather Hite, RN (August 26 and 27, 2013) Caitlyn Doyle, RN Jennifer Redlin, RN</p> <p>Census bed type: SNF: 39 SNF/NF: 19 Residential: 55 Total: 113</p> | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155795 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 08/28/2013 |
| NAME OF PROVIDER OR SUPPLIER AVALON SPRINGS HEALTH CAMPUS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2400 SILHAVY ROAD VALPARAISO, IN 46383 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | <p>Continued From page 1</p> <p>Census Payor type:</p> <p>Medicare: 34</p> <p>Medicaid: 10</p> <p>Other: 69</p> <p>Total: 113</p> <p>Sample: 8</p> <p>Avalon Springs Health Campus was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the investigation of Complaints IN00132541, IN00132978, and IN00134933.</p> <p>Quality review completed on September 2, 2013, by Janelyn Kulik, RN.</p> | F 000 | | | |